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Issue Date: 24 September 2004

Case No. 2003-BLA-5453

In the Matter of

ROANLD MARTIN
Claimant

v.

NATIONAL MINES CORP.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest

Appearances:

Susie Davis, Lay Representative
For the Claimant

Denise M. Davidson, Esq.
For the Employer

BEFORE: MOLLIE W. NEAL
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This case arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977 (hereinafter referred to as "the Act"), 30 U.S.C. § 901 *et seq.*, and the regulations issued thereunder, located in Title 20 of the Code of Federal Regulations ("C.F.R."). Regulation section numbers mentioned in this Decision and Order refer to sections of that Title. Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a chronic dust disease of the lungs arising from coal mine employment and is commonly known as black lung.

Ronald Martin, (the "Claimant") has filed two prior claims for benefits under the Act. The first claim, filed December 6, 1984, was finally denied by Administrative Law Judge Richard D. Mills by Decision and Order dated May 5, 1988.[1] (DX 1) Judge Mills found that the Claimant had established clinical pneumoconiosis, but that the evidence did not establish that he was totally disabled by pneumoconiosis. That claim was not pursued further, and was administratively closed.

The Claimant filed a second claim for benefits on June 9, 1992 (DX 2), which was denied by the District Director, Office of Workers' Compensation Programs, OWCP, on November 16, 1992. (DX 2). The District Director found that the miner had failed to establish any of the elements necessary to entitle him to benefits under the Act. (DX 2). Claimant did not seek to modify or appeal the denial, and the claim was administratively closed.

Mr. Martin filed the instant claim for benefits on May 15, 2001. (DX 4). The District Director awarded benefits by Proposed Decision and Order on October 30, 2002, finding that Claimant established all of the elements necessary to entitle him to benefits under the Act. (DX 38). Employer filed a timely request for a hearing and the matter was referred to the Office of Administrative Law Judges for a formal hearing, on February 6, 2003. (DX 40, DX 48).

After due notice, a formal hearing was held before me in Prestonburg, Kentucky on January 14, 2004. At that time, all parties were afforded a full opportunity to present evidence and argument as provided in the Act and the regulations. At the hearing, Director's exhibits 1-49; and Employer's exhibits 1-6 were admitted into the record. (Tr. 5, Tr. 8). Employer submitted a post-hearing brief, and the record is now closed.

The findings of fact and conclusions of law which follow are based upon my thorough analysis and review of the entire record, arguments of the parties and applicable statutes, regulations and case law.

Issues

The issues to be adjudicated are: (1) whether Claimant has pneumoconiosis as defined by the Act and the regulations; and if so (2) whether his pneumoconiosis arose out of coal mine employment; (3) whether Claimant is totally disabled; and if so (4) whether that total disability is due to pneumoconiosis and (5) whether Claimant has established that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. (DX 48, Tr. 9-10).

Adjudicatory Rules

Because this claim was filed in 2001, it is governed by the regulations at 20 C.F.R. Part 718. Under Part 718, the claimant must prove by a preponderance of the evidence that: (1) he suffers from pneumoconiosis; (2) such pneumoconiosis arises out of coal mine employment; (3)

[1] The following references will be used herein: "DX" designates Director's exhibits; "EX" designates Employer's exhibits; and "Tr." Designates the transcript of the hearing held on January 14, 2004.

he is totally disabled; and (4) coal workers' pneumoconiosis contributes to the total disability. 20 C.F.R. §725.202(d) (2) (2001); *Gee v. W.G. Moore & Sons,* 9 BLR 1-4 (1986) (en banc); *Baumgartner v. Director, OWCP,* 9 BLR 1-65 (1986) (en banc). Evidence which is in equipoise is insufficient to sustain the claimant's burden of proof. *Director, OWCP v. Greenwich Collieries, et al.,* 114 S.Ct. 2251 (1994); *aff'g sub nom. Greenwich Collieries v. Director, OWCP,* 990 F.2d 730 (3d Cir. 1993). Failure to establish any one of these elements precludes entitlement to benefits.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Dependents

The Claimant has one dependent for purposes of augmentation of benefits, his wife Sylvia. (DX 11; Tr. 11).

Length of Coal Mine Employment

Based upon the documented coal mine employment history in this record, (DX 5, DX 7, DX 8, and DX 9) and the miner's testimony during the hearing (Tr. 9), I find that he was a coal miner, as that term is defined by the Act and the regulations, for a period of at least thirteen years. He stopped working as a coal miner in 1984 because of injuries sustained to his back, neck and shoulder in a work related accident. (Tr. 15)

Responsible Operator

National Mines Corp. does not deny that it is the coal mine operator responsible for the payment of benefits on this claim. (Tr. 9). *See also* Employer's Brief pp 21-22. Accordingly, I find that National Mines Corporation is the responsible operator in this matter.

Section 725.309 Subsequent Claim

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim; *see 20 C.F.R. §725.310*. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim which will be denied on the basis of the prior denial unless the claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. § 725.309(d) (2001). In the Sixth Circuit Court of Appeals, the jurisdiction within which this claim arises, the Court has indicated that to assess whether a material change had been established under S§725.309(d) in effect prior to January 19, 2001 (the effective date of the amended regulations),

> [T]he ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then, the ALJ must consider whether all of the record evidence, including that submitted with the

previous claims, supports a finding of entitlement to benefits.

Sharondale Corp. v. Ross, 42 F.3d 993, 997-998 (6th Circuit 1994): The standard and analytical framework enunciated in *Sharondale Corp v. Ross* is now codified in the 2001 Amendments.

Under the regulations, the applicable conditions of entitlement are limited to those conditions upon which the prior denial was based. *20 C.F.R. § 725.309(d) (2*). In the denial of the prior claim herein, OWCP found that the claimant failed to establish the existence of pneumoconiosis and total disability. Therefore, my inquiry begins with an analysis of whether the newly submitted evidence establishes either of these elements of entitlement.[2]

Summary of New Evidence.

The admissible evidence submitted since the denial of the prior claim is summarized as follows:

Ex. No.	Date of X-ray	Physician/Qualifications[3]	Impression
DX 13	9/8/01	Baker	1/0
DX 14	9/8/01	Sargent, BCR/B	Read for quality Only; Quality = 2
EX 2	9/8/01	Wiot, BCR/B	Negative
DX 29	9/20/01	Wiot, BCR/B	Negative
DX 29	9/20/01	Dahhan, B	Negative
EX 1	11/22/03	Dahhan, B	Negative

[2] Section 725.309(d)(4) provides that:

> If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see §725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in the adjudication with the prior claim shall be binding on that party in the adjudication of the subsequent claim. *20 C.F.R. §725.309(d) (4) (2001)*.

[3] The symbol "B" denotes a physician who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. §37.51 (1982).

The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc. or the American Osteopathic Association. 20 C.F.R. §727.206(b) (2) (iii).

Pulmonary Function Studies[4]

Ex. No.	Date	Physician	Age/Height	FEV1[5]	FVC	MVV
DX 13[6]	9/8/01	Baker	52/71.25	2.25	4.74	86
DX 29	9/20/01	Dahhan	52/70.1	2.48 2.51*	4.44 4.37*	68 84*
EX 1	11/22/03	Dahhan	55/66.2	1.74 2.12*	3.35 3.98*	58 59

Arterial Blood Gases

Ex. No.	Date	Physician	PCO2[7]	PO2
DX 13[8]	9/8/01	Baker	40	61
DX 29	9/20/01	Dahhan	40.7	76.3
EX 1	11/22/03	Dahhan	36.7	70.9

Medical Opinions

Claimant was examined by Dr. Glen Baker September 8, 2001. Dr. Baker noted fourteen years of surface coal mine employment as a heavy equipment operator. Claimant related a cigarette smoking history of one half packs per day for ten years, on and off. Based upon his examination, a positive reading of Claimant's chest x-ray, non-qualifying pulmonary function and arterial blood studies, subjective symptoms of coughing, sputum production and wheezing, Dr. Baker diagnosed coal workers' pneumoconiosis, chronic obstructive pulmonary disease with a moderate obstruction, chronic bronchitis, and moderate hypoxemia, both due to coal dust exposure and cigarette smoking. Dr. Baker is board-certified in internal medicine with a subspecialty in pulmonary disease. (DX 13)

[4] The October 16, 2001 pulmonary function study which is included in the Summary of Evidence in Employer's Brief was excluded by the District Director as untimely submitted, and was returned to the Claimant's representative (DX 39). That ventilatory study was not resubmitted in this record.

[5] An "*" indicates that the test results were obtained after the administration of bronchodilator medication.

[6] This testing was reviewed by Dr. J. Michos and determined to be of acceptable quality. (DX 13).

[7] An "*" indicates that the test results were obtained after the administration of exercise.

[8] This arterial blood gas study was reviewed by Dr. J. Michos. Dr. Michos found the test to demonstrate acceptable quality. (DX 13).

In a report, dated August 21, 2001, Dr. Gregory Fino reviewed all of the medical records developed by the Employer as of that date. Those records included the March 21, 1985 medical report of Dr. Bruce Broudy, the x-ray and pulmonary function study administered by Dr. Broudy, and chest x-ray readings of x-rays dated June 16, 1987 and August 4, 1992. Based on negative x-ray readings, normal spirometric evaluation which showed neither obstruction, or restriction, or a ventilatory impairment, Dr. Fino found insufficient data to justify a diagnosis of coal workers pneumoconiosis, and concluded that Mr. Martin did not have an occupationally acquired pulmonary condition resulting from coal mine dust exposure. (DX 16)

On September 11, 2001, Dr. Ben Branscomb reviewed the miner's medical records contained in the prior claim file. The only new medical record reviewed was the report of a medical examination of the Claimant by Dr. Potter, on December 13, 1993, for a back injury. (DX 17). Dr. Branscomb noted that Claimant's coal mine employment was above ground, thus resulting in low exposure to coal mine dust. He stated that Claimant's cigarette smoking history is not one that he would expect to result in a significant tobacco related pulmonary disease.[9] He considered the negative x-ray readings of the March 20, 1985, June 16, 1987 and August 14, 1992 chest x-rays, and normal pulmonary function studies and blood gas studies dated December 18, 1984 and March 20, 1985. Based upon his review of the record, Dr. Branscomb found no medical evidence to support a diagnosis of the presence of dust related pulmonary disease.

Dr. A. Dahhan examined the miner on September 20, 2001 and November 22, 2003. (DX 29, EX 1). He noted fourteen years of coal mine employment as well as Claimant's previous jobs in the coal mining industry. In his first report he recorded Claimant's smoking history to include smoking one-half pack of cigarettes per day beginning at age 16,[10] but reduced to a few cigarettes per day six months prior to the examination. In his later report, he indicated a smoking history of one-half pack of cigarettes per day beginning at age twenty-one. Claimant's chest x-rays were negative for pneumoconiosis. However, the most recent x-ray showed hyperinflated lungs consistent with emphysema. The pulmonary function study dated September 20, 2001 revealed mild obstructive ventilatory defect caused by smoking, and arterial blood gas testing showed normal values. November 2003 ventilatory studies showed a moderate partially reversible obstructive ventilatory defect, and blood gases disclosed minimum hypoxemia at rest. Dr. Dahhan found insufficient objective data to justify a diagnosis of coal workers' pneumoconiosis. He did diagnose chronic obstructive pulmonary disease unrelated to coal dust exposure. Dr. Dahhan is board certified in internal medicine and pulmonary disease. (EX 1)

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[9] Dr. Branscomb noted a cigarette smoking history of one fourth packs of cigarettes a day for over a ten year period. However, the smoking history considered by Dr. Branscomb was not accurate. As discussed herein, I have found that Mr. Martin's smoking history equates to one pack of cigarettes a day for at least fifteen years.

[10] Claimant testified at his deposition on October 8, 2003, that he smoked cigarettes for approximately fifteen years (EX 6, p. 16) At the hearing, he took issue with Dr. Dahhan's statement that he started smoking history at age 16, and indicated that he told Dr. Dahhan he started smoking at the age of 21. (Tr. 12, Tr. 17) It is noted that, although Dr. Dahhan recorded an earlier age at which Claimant began smoking in his initial report, he subsequently considered, in his November 28, 2003 report, a history consistent with Claimant's testimony. (EX 1) Assuming Claimant's account of his smoking history to be accurate (i.e. that he started at age 21), and considering his date of birth of November 7, 1948, his smoking history would be at a minimum 15 pack years. I reach this conclusion, without taking into account the fact that, on Dr. Dahhan's examination in 2001, the carboxyhemoglobin test he administered was consistent with an individual smoking over a pack a day.

Dr. Jarboe submitted an initial consultative report of his review of Claimant's medical records and a supplemental report after review of additional medical records. He also gave deposition testimony. In his report dated October 2, 2003, after reviewing Dr. Broudy's 1985 report, Dr. Terry Wright's 1987 report, Dr. Ira Potter's August 4, 1992 report, and the 2001 reports of Drs. Dahhan and Baker, Dr. Jarboe found insufficient data to justify a diagnosis of coal workers' pneumoconiosis based upon the chest x-ray readings of the B-readers in the record. Dr. Jarboe also indicated that the pulmonary function studies do not disclose a pattern of dust induced lung disease. Dr. Jarboe offered a supplemental report dated November 18, 2003, after reviewing Dr. Potter's records for the period September 6, 1985 through August 20, 2003. Based upon this review, he concluded Claimant had "two significant risk factors for the evolution of significant airflow obstruction." He noted Dr. Potter's observation during the April 25, 2003 examination that Mr. Martin had smoked heavily for many years. He also noted that the medical treatment records confirm that Mr. Martin is asthmatic and has been treated with steroids (Advair and Singulair), which are used to treat bronchial asthma. Noting that asthma is a significant risk factor for the development of airflow obstruction, Dr. Jarboe concluded that Mr. Martin's obstructive lung disease has been caused by a combination of cigarette smoking and bronchial asthma. Dr. Jarboe is board-certified in internal medicine and pulmonary diseases, and is a B-read. (EX 3).

Treatment Records of Dr. Ira Potter

The treatment records of Dr. Ira Potter for the period September 6, 1985 through August 20, 2003 were admitted into evidence pursuant to 20 C.F.R. §725.414(a)(4). (EX 5). Included in those records are numerous treatment notes, medical evaluations by Dr. Potter, and diagnostic test results. In my initial analysis, I have considered only the records relating to Mr. Martin's condition after the date of the prior denial. The relevant evidence in Dr. Potter's records is summarized herein.

Dr. Potter has treated the Claimant for chronic back pain, lumbosacral strain, anxiety, and various other non-pulmonary related conditions. On December 23, 2002 he rendered an opinion that Mr. Martin was permanently disabled due to back injury. No mention was made of a disability due to pulmonary impairment.

His treatment records repeatedly note symptoms of coughing and wheezing, and a diagnosis of COPD. Dr. Potter also referred Mr. Martin to Dr. Rahu Sandaram for symptoms of smothering, weight loss and productive cough, on May 6, 2001. Dr. Sandaram's impression was COPD with exacerbation and coal workers' pneumoconiosis. His opinion was based in part on a chest x–ray report dated January 26, 2001. Dr. Sandaram prescribed Advair Discus and Singulair. In a letter dated September 24, 2001, Dr. Ira Potter stated that Mr. Martin was disabled with pneumoconiosis and COPD. His treatment therapy included Brethine and Albuterol, and a nebulizer and home oxygen treatment was recommended. (DX 15) In an examination report of April 25, 2003, Dr. Potter diagnosed a history of COPD, chronic low back pain, general anxiety disorder, but made no mention of pneumoconiosis

A CT-scan of Claimant's chest, dated February 19, 2002, that was interpreted by Dr. Mahender Pampati, as showing the "visualized lung fields" to be "unremarkable

The following x-ray reports were included in Dr. Potter's treatment records, some of which have been re-read by Employer and submitted as rebuttal evidence. While these x-ray reports were not admitted as initial or rebuttal evidence in either party's case in chief, they are relevant in evaluating the treating physician's opinion.

Ex. No.	Date of x-ray	Physician/Qualifications	Impression
EX 5	1/08/99	Datu	peribronchial curring and thickening suggestive of bronchitis
EX 5	12/01/99	Bofill	no active disease
EX 5	9/17/01	Potter	1/2
EX 2	9/17/01	Wiot, BCR/B	Negative
EX 5	9/25/01	Pampati	COPD
EX 5	12/29/02	Sakow	Normal
EX 4	2/18/03	Wiot, BCR/B	Negative
EX 5	2/18/03	Gabier	Increasing fibrosis and COPD
EX 4	5/13/03	Wiot, BCR/B	Negative
EX 5	5/13/03	Patel	COPD, no active cardiopulmonary disease
EX 5	7/23/03	Patel	COPD, no active cardiopulmonary disease

Other x-ray reports in the file dated January 8, 1999, December 1, 1999 mention acute bronchitis by history, but specifically note "no active pulmonary disease changes." An x-ray taken on April 30, 2001 was interpreted as showing mild fibroemphysematous changes without superimposed lung disease process. Dr. Wiot reviewed x-rays dated May 5, 1999 and June 12, 1999 from "ARH." (EX 4) I can find no mention of the existence of these x-rays in the record and will not consider his readings of these x-rays. Dr. Wiot also reviewed x-rays dated February 18, 2003 and May 13, 2003 which are included in Dr. Potter's treatment records, as well as the CT scan dated February 19, 2002. These documents are relevant and admissible as rebuttal of reports contained in Dr. Potter's treatment notes.

Pneumoconiosis and Causation

The term "pneumoconiosis" has both a medical and a legal definition. See, e.g., *Clinchfield Coal Co. v. Fuller,* 80 F.3d 622, 625 (4th Cir.1999); *Hobbs v. Clinchfield Coal Co.,* 45 F.3d 819, 821 (4th Cir.1995). Medical pneumoconiosis is a particular disease of the lung generally characterized by certain opacities appearing on a chest x-ray. *See Usery v. Turner Elkhorn Mining Co.,* 428 U.S. 1, 6-7, 96 S. Ct. 2882, 49 L.Ed.2d 752 (1976); *see also Hobbs,* 45 F.3d at 821. Legal pneumoconiosis is a much broader category of diseases, which includes but is

not limited to medical, or "coal workers'," pneumoconiosis. *See Fuller,* 180 F.3d at 625; *Hobbs,* 45 F.3d at 821; *see also* 20 C.F.R. §§ 718.201 (including within legal definition of "pneumoconiosis" "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment").The presence of pneumoconiosis, as defined at 20 C.F.R. §718.201, is determined under the criteria at 20 C.F.R. §718.202(a) (1)-(4). In this claim, there is no autopsy or biopsy evidence, and none of the presumptions at §718.202(a) (3) is applicable. Thus the presence of pneumoconiosis must be established by chest rays or reasoned medical opinions under §§718.202(a) (1) or (4), respectively.

Under the provisions of §718.202(a)(1), chest x-rays that have been taken and evaluated in accordance with the requirements of §718.102 may be used as a basis for a finding of the existence of pneumoconiosis if classified in Category 1, 2, 3, A, B or C under an internationally-adopted classification system. An x-ray classified as Category 0, including subcategories 1/-, 0/0 and 0/1 does not constitute evidence of pneumoconiosis. Under §718.202(a) (1), when two or more x-ray reports are in conflict, consideration must be given to the radiological qualifications of the physicians interpreting the x-rays. *See Herald v. Director, OWCP,* BRB No. 94-2354 BLA (Mar. 23, 1995) (unpublished). *See also Sexton v. Director, OWCP,* 752 F.2d 213 (6th Cir. 1985).

The newly submitted x-ray ray reports include one positive reading of the September 8, 2001 chest film by Dr. Baker, and a negative reading of the same film by Dr. Wiot. Dr. Sargent read this x-ray for quality only. Dr. Jarboe's reading of this chest film is cumulative in probative value. Because this x-ray reading would be excluded under §725.414(a) (3) (ii), it has not been considered.[11] (See EX 3) The remaining two chest x-rays dated September 20, 2001 and November 22, 2003 were read as negative by B-readers. When the x-ray reports are conflicting, greater consideration will be given to the readings of the physicians who possess superior radiological qualifications. *20 C.F.R. §718.202(a) (1*). Readers who are board-certified and/or B-readers are classified as the most qualified. *Sheckler v. Clinchfield Coal Co.,* 7 B.L.R. 1-128, 1-131 (1984). Based on the weight of the negative x-ray readings by the B-readers and board-certified radiologists, I find the preponderance of the newly submitted x-ray reports to be negative for the existence of pneumoconiosis. Therefore, Claimant cannot establish pneumoconiosis pursuant to §718.202(a) (1).[12]

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[11] Section 725.414(a)(3)(ii) provides that the responsible operator is entitled to submit, in rebuttal of the case Claimant's case, one physician's interpretation of each chest x-ray, pulmonary function, test, arterial blood gas study submitted by the claimant under subsection (a)(2)(i) and by the district director pursuant to §725.406. Medical evidence in excess of the limitations set forth at § 725. 414 shall not be admitted absent a showing of good cause. The regulation was intended to level the playing field between the parties. In applying the regulation on a case by case basis, the administrative law judge has broad discretion to exclude excessive evidence which lacks significant probative value, particularly in a case involving repetitious, cumulative and unnecessary evidence. *Underwood v. Elkay Mining, Inc.*, 105 F.3d 946 (4th Cir. 1997). Dr. Jarboe's x-ray reading will be excluded as it is repetitious and cumulative.

[12] Dr. Potter's medical treatment records include one positive x-ray reading of a chest film dated September 17, 2001. If this x-ray report were considered, in conjunction with the newly submitted r-ray evidence, my determination under §718.202(a) (1) would remain the same. Since the record does not indicate that Dr. Potter possesses special radiological qualifications for reading chest x-rays, his opinion would be outweighed by that of Dr. Wiot who interpreted the x-ray as negative.

Pursuant to §718.202(a) (4), a claimant may also establish the existence of pneumoconiosis, notwithstanding negative x-rays, by submitting reasoned medical opinions establishing the existence of pneumoconiosis. However, any such finding by a physician must be based on objective medical evidence. A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co., 10 B.L.R. 1-65, 1-66 (1985).* Statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988). A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984).

All of the records reviewed by Dr. Fino were in existence at the time of the denial of the miner's prior claim on November 16, 1992 and relate to the miner's condition prior to that date. Since Dr. Fino's opinion is not based on any new medical documents, it is of little probative value regarding the preliminary question presented in this claim, eg. whether one or more of the applicable conditions of entitlement has changed since November 16, 1992. In fact, the fact finders in the previous claims considered those medical records in reaching denial determinations. Dr. Fino's opinion, therefore, will not been considered in my determination of whether the evidence establishes an element of entitlement upon which the prior claim was denied.

For reasons similar to those discussed regarding Dr. Fino's report, Dr. Branscomb's medical report is likewise of little value in my analysis of whether one of the elements of entitlement has change since the denial of the prior claim. His opinion is not based on new evidence. The records reviewed by Dr. Branscomb were developed during the pendency of the prior claims, except for a report of Dr. Potter dated December 13, 1993, relating to a follow up examination of the miner for a non pulmonary condition (an old back injury).

Dr. Baker diagnosed coal workers' pneumoconiosis and chronic obstructive pulmonary disease due to coal dust exposure and smoking. Dr. Potter, Claimant's treating physician, diagnosed coal workers' pneumoconiosis, but provides no basis for how he reached this diagnosis. His treatment records indicate that his diagnosis may be based on positive chest x-ray readings, the opinion of Dr. Sandaram, and upon a finding that Mr. Martin's COPD was related in part to coal dust exposure. However, I do not find either physician's opinion to be as well reasoned or as credible as that of Dr. Jarboe or Dr. Dahhan for the following reasons.

While the opinions of treating and examining physicians may deserve special consideration, they are not required to be given greater weight than opinions of other expert physicians. *Sterling Smokeless Coal Company v. Akers*, 131 F. 3d 438 (4th Cir. 1997). Dr.

Potter's opinion (and the opinion of Dr. Sandaram to the extent that it is incorporated in Dr. Potter's records) is accorded less weight for several reasons. Both physicians relied on positive x-ray readings in diagnosing clinical pneumoconiosis. I have found the x-ray evidence to be negative for the presence of pneumoconiosis. In addition, Dr. Potter possesses no special radiological qualification for reading chest x-rays. Thus, to the extent that his clinical diagnosis of pneumoconiosis rests entirely on his x-ray readings, it is outweighed by the opinions of the more qualified B-readers and board-certified radiologists who found the positive x-rays he relied upon to be negative for the presence of pneumoconiosis. Dr. Sandaram's diagnosis of pneumoconiosis is undermined by the fact that he based his opinion on inadmissible evidence (an x-ray not included in this record). Finally, Dr. Potter's diagnosis of COPD does not satisfy the legal definition of pneumoconiosis, since he did not provide a rationale and supporting findings for a diagnosis of coal dust induced pneumoconiosis. See *Tussey v. Island Creek Coal* 982 F. 2d 1036, 17 BLR 2-16 (6th 1993).

Similarly, Dr. Baker's diagnosis of coal workers' pneumoconiosis, to the extent that it is based on x-ray evidence is also less persuasive. Further, Dr. Baker's diagnosis of COPD due to coal dust exposure and smoking is not well reasoned and documented, because he considered an erroneous smoking history of five pack years (one half pack of cigarettes for ten years), and Claimant has been found to have a significantly greater smoking history of fifteen pack years.

Doctor Jarboe found that Claimant is not suffering from pneumoconiosis based on the negative readings of the B-readers. He also found that the pulmonary function studies do not support a diagnosis of dust induced pulmonary disease. Instead, he attributed Claimant's airflow obstruction to smoking and bronchial asthma. Dr. Jarboe diagnosed COPD, unrelated to coal dust exposure, resulting from his extensive smoking history and bronchial asthma. His analysis of Dr. Potter's treatment records and finding of bronchial asthma as a contributing factor in the miner's airflow obstruction is well reasoned and supported by the record evidence. I defer to Dr. Jarboe's superior qualifications. Dr. Dahhan also did not diagnose coal workers' pneumoconiosis, but found a mild obstructive defect resulting from Claimant's cigarette smoking. Doctors Jarboe and Dahhan are board certified in internal medicine and pulmonary disease, and are highly specialized in pulmonary medicine, and their opinions are accepted as well reasoned and documented.

After full consideration of all of the relevant physician opinions of record as well as the qualifications of the physicians rendering those opinions, I find the opinions of Drs. Jarboe and Dahhan to be more credible than the opinion of the treating physician who possesses no special qualifications in this record, and the opinion of Dr. Baker. I attribute the most weight to the opinions of Dr. Jarboe and Dahhan as they are more comprehensive, reasoned and documented by the available objective medical data. For the reasons discussed above, I find that their opinions outweigh the contrary opinion of Dr. Baker who is equally qualified.

In summary, Claimant has failed to establish the existence of pneumoconiosis by a preponderance of the physician opinion evidence pursuant to §718.202(a) (4).

Total Disability

Benefits under the Act are provided for miners who are totally disabled due to pneumoconiosis. A miner shall be considered totally disabled if the irrebuttable presumption of §718.304 applies. The irrebuttable presumption set forth at Section 718.304 provides that if a miner is suffering from a chronic dust disease of the lungs that yields one or more large opacities on chest x-ray which would be classified as Category A, B or C or one or more massive lesions on biopsy, then such miner shall be presumed to be totally disabled due to pneumoconiosis. 20 C.F.R. §718.204(b), 20 C.F.R. §718.304. There is no such evidence of record and thus total disability is not established by the irrebuttable presumption of §718.304 as provided in §718.204(b).

Total disability may also be established if pneumoconiosis prevents a miner from performing his usual coal mine work or comparable and gainful employment. *20 C.F.R. §204(b).* In the absence of contrary probative evidence, evidence which meets one of the standards of §718.204(b) (2) (i)-(iv) may establish a miner's total disability. I note at the outset that subsection (b) (2) (iii) is not applicable because there is no evidence that Claimant suffers from cor pulmonale with right-sided congestive heart failure.

Pulmonary function studies can establish total disability where the values are equal to or less than those listed in Table B1 in Appendix B to Part 718. An assessment of these results is dependent on Claimant's height which is recorded as 71.25, 70.1 and 66.2 inches. Considering this discrepancy, I find Claimant's height to be 69.2 inches for the purposes of evaluating the pulmonary function studies. *Protopassas v. Director, OWCP,* 6 B.L.R. 1-221 (1983). The most recent pulmonary function study, dated November 22, 2003, produced values which satisfy the disability criteria under the applicable regulation. Therefore, a totally disabling respiratory impairment has been established pursuant to §718.204(b) (2) (i).

Under the provisions of subsection 718.204(b)(2)(ii), a claimant can establish total disability if the arterial blood gas tests show values conforming to Appendix C to Part 718. None of the blood gas studies produced values indicative of total disability. Accordingly, I find that total disability has not been established pursuant to 20 C.F.R. §718.204(b) (2) (ii).

The final method by which Claimant can establish total disability is through medical opinion evidence wherein a physician has exercised reasoned medical judgment based on medically acceptable clinical and laboratory diagnostic techniques to conclude that the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment or comparable employment. *20 C.F.R. §718.204(b) (2) (iv)*

Dr. Potter stated that Claimant is disabled by coal workers' pneumoconiosis and COPD. His opinion is, however, of little value because it is not documented by objective diagnostic testing, and does not state the findings which form the bases for his opinion. Therefore, Dr. Potter's opinion is insufficient to establish total disability.

Dr. Baker found that Claimant suffers from a moderate respiratory impairment as established by his decreased FEV1 and PO2. Dr. Baker attributed this moderate respiratory impairment to Claimant's chronic bronchitis and coal workers' pneumoconiosis. Dr. Baker was of the opinion that Claimant's impairment would prevent him from engaging in coal mine employment because of his decreased FEV1 which was 57% of predicted.

The opinions of Drs. Fino and Branscomb are based on medical evidence in existence prior to the denial of the previous claim. Therefore, their disability assessments relate to the miner's condition prior to the 1992 denial of his previous claim and are not relevant herein.[13]

Dr. A Dahhan initially concluded that Mr. Martin was not totally disabled (DX 29). Dr. Dahhan found the miner to be suffering from a mild obstructive ventilatory defect. (DX 29). He did not find the existence of any permanent or total pulmonary disability. Dr. Dahhan attributes Claimant's mild defect to his cigarette smoking history. A carboxyhemoglobin test was performed at the time of his examination of Claimant, and the results of that testing indicated that Claimant was smoking over one pack of cigarettes per day at the time of the examination. Dr. Dahhan further stated that Claimant coal dust exposure was insufficient to have caused an injury to Claimant's respiratory system. However, following his examination on November 22, 2003, Dr. Dahhan concluded that Claimant does not "retain the physiological capacity to continue his previous coal mine employment or a job of comparable demand." Dr. Dahhan attributed Claimant's respiratory impairment to his lengthy smoking habit, observing the absence of evidence of a "pulmonary impairment and/or disability caused by, related to, contributed to or aggravated by inhalation of coal dust or coal workers' pneumoconiosis."

Dr. Jarboe found a mild to moderate respiratory impairment, but that Claimant was not totally disabled. He stated that Claimant "fully retains the respiratory capacity to do his last coal mine employment or one of similar physical demand in a dust free environment." (EX 3, Medical Opinion, dated October 2, 2003). Dr. Jarboe was of the opinion that the Claimant does not suffer from any coal dust related respiratory or pulmonary condition. (EX 3, Deposition Transcript, pp. 16, 21)

After considering all the relevant medical opinions, I find that the Claimant has not established the existence of a totally disabling respiratory impairment pursuant to 20 C.F.R. §718.204(b). Dr. Potter found Claimant to be totally disabled by coal workers' pneumoconiosis. However, his opinion is not accepted for the reasons discussed *supra.* [14] Drs. Dahhan and Baker

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[13] Dr. Fino stated that Claimant does not suffer from any respiratory impairment. (DX 16). He further stated that "from a respiratory standpoint, [Claimant is] neither partially nor totally disabled from returning to his last coal mine job or a job requiring similar effort." Dr. Fino opined that even if the miner were found to be suffering from pneumoconiosis, his opinion as to Claimant's respiratory impairment would not change.

Dr. Branscomb found that based upon his review of the record, the miner does not suffer from any pulmonary impairment as a result of his coal dust exposure. (DX 17). Dr. Branscomb further found no "adverse pulmonary effect" as a result of the miner's exposure to coal dust.

[14] I note that Potter appears to have relied on Dr. Sandaram's evaluation and that Dr. Sandaram apparently did administer a pulmonary function study, which has been excluded from the record. As such, Dr. Sandaram's opinion

believed the miner to be totally disabled. Dr. Jarboe, on the other hand, offered a contrary opinion. The disability assessments of both Dr. Baker and Dr. Dahhan are documented and reasoned. Dr. Dahhan, who examined the miner twice – once in 2001 and again 2003 – ultimately found the miner to be totally disabled, based in part on a qualifying pulmonary function study. Dr. Baker reached his disability assessment based on a valid pulmonary function study which revealed significantly decreased FEV1 value. Both physicians' opinions are accepted over that of Dr. Jarboe who found that Claimant retained the physical capacity to perform his coal mine employment, notwithstanding his mild to moderate respiratory impairment. However, Dr. Jarboe did not have the benefit of the most recent qualifying pulmonary function study when he rendered his decision. The preponderance of the credible physician opinion evidence indicates that Claimant has a totally disabling respiratory condition. Therefore, I find that Claimant establish the total disability pursuant to §718.204(b) (2) (iv)

Etiology of Total Disability

In a part 718 claim, such as this, Claimant has the burden of proving not only total disability, but also that the total disability is due to pneumoconiosis. Even if the arterial blood gas tests and pulmonary function studies are qualifying to prove total disability, the board has consistently held that blood gas tests and pulmonary function studies are not diagnostic of the etiology of respiratory impairment, but are diagnostic only of the severity of the impairment. *Tucker v. Director, OWCP,* 10 B.L.R. 1-35, 1-41 (1987). Thus a claimant who established total disability through arterial blood gas tests or pulmonary function studies has not also established that the disability is due to pneumoconiosis. *Id.*

I have found Claimant to be totally disabled from a respiratory standpoint. A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. 20 C.F.R. §718.204(c) (1). Pneumoconiosis is considered a substantially contributing cause if the miner's disability:(1) has a material adverse effect on the miner's respiratory or pulmonary condition;(2)materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. *20 C.F.R. §718.204(c) (1) (i)-(ii).*

Dr. Dahhan found the existence of a totally disabling respiratory impairment, resulting from Claimant's smoking history. Dr. Baker, on the other hand, attributed the miner's total disability to coal workers' pneumoconiosis and smoking. As discussed previously, however, Dr. Baker's diagnosis of COPD caused by coal dust and smoking was based on an erroneous smoking history, and his diagnosis of coal workers' pneumoconiosis is not supported by the preponderance of the x-ray evidence of record. Therefore, Dr. Dahhan's opinion relating to the cause of the miner's disabling respiratory impairment is accepted over that of Dr. Baker.

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cannot be relied upon. Even it the results of that test had been admissible, according to Dr. Jarboe, the study was invalid due to suboptimal effort.

Consideration of Evidence from Prior Claim

I have reviewed the evidence from Claimant's previous two claims. In order to prevail, Claimant must show that his total disability is caused by coal workers' pneumoconiosis. My review of all the evidence in this record leads me to conclude that he cannot satisfy that burden of proof. The evidence does not support a finding that Mr. Martin has coal workers' pneumoconiosis. I reach that conclusion based on the preponderance of the negative x-ray readings, including the x-ray reports in Dr. Potter's treating records, and the physician opinions of record. According the greatest weight to the opinions of the B-readers and/or Board-certified radiologists, the preponderance of the x-ray readings before Judge Mills and the district director in the subsequently filed claim was negative for pneumoconiosis. (See x-rays dated, December 18, 1984, March 20, 1985, August 4, 1992, and September 17, 2001).[15] For reasons fully discussed herein, the newly submitted x-ray evidence is also negative. Thus, pneumoconiosis has not been established by x-reports. Similarly, claimant cannot establish pneumoconiosis by a preponderance of the physician opinions. In the earlier claim files Drs. Cordell Williams, Bruce Broudy, did not diagnose pneumoconiosis, while Dr. Terry Wright diagnosed the disease. Dr. Potter diagnosed coal workers' pneumoconiosis based on his positive x-reading in 1992. When these physicians opinions are weighed with the opinions in the current claim the preponderance of the physicians' opinions is negative for the disease .In the current claim file, the credible opinions of Drs. Dahhan, Jarboe, Broudy, Branscomb and Fino, all found the miner did not have coal workers' pneumoconiosis. Only Drs. Potter, Sandaram, Wright and Baker reached contrary diagnoses. When the impediments in the opinions of Drs. Potter, Sandaram and Baker, as discussed previously herein, are considered, the overwhelming weight of the physician opinions is negative for the presence of pneumoconiosis. Since the evidence does not establish that the Claimant has coal workers' pneumoconiosis, it necessarily follows that he cannot demonstrate that coal worker's pneumoconiosis has a material adverse effect on his respiratory condition, or that it worsens a totally disabling respiratory impairment caused by a disease or exposure unrelated to coal mine employment..

In conclusion, after consideration of all of the evidence of record, I find that while Claimant has established a totally disabling respiratory condition, that condition is not a result of pneumoconiosis. Claimant has also failed to establish that he suffers from pneumoconiosis arising out of coal mine employment.

Entitlement

Considering that Claimant has failed to establish a pneumoconiosis arising out of coal mine employment and that his total disability is due to coal workers' pneumoconiosis, his claim must be denied.

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[15] The March 20, 1985 chest film was read by two dually qualified physicians Drs. Quillin and Sargent. The June 16, 1987 x-ray was read by Aycoth, a B-reader as positive and by Quillin, a dually certified physician as negative. I defer to Dr. Quillin, given his superior qualifications and find this chest film to be negative. Dr. Potter, who possesses no special radiological qualifications, is the only physician who found the August 4, 1992 chest x-ray to be positive. Drs. Shipley, Spitz, and Wiot, B-readers, and Dr. Sargent, a B-reader and board-certified radiologist, all read this x-ray as negative for pneumoconiosis. Dr. Potter read the September 17, 2001 x-ray as positive and Dr. Wiot a B-reader found the x-ray to be negative for pneumoconiosis.

Representative's Fees

The award of a representative's fee under the Act is permitted only in cases in which a claimant is found to be entitled to the receipt of benefits. Because benefits are not awarded in this claim, the Act prohibits the charging of any fee to Claimant for services rendered in pursuit of benefits.

ORDER

It is therefore ORDERED that the claim of Ronald Martin for benefits under the Act is h

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MOLLIE W. NEAL
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor, 200 Constitution Avenue, NW, Room N-2117,